Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: INTEGRA SPECIALTY GROUP, P.A. 517 N. CARRIER PKWY. STE. G GRAND PRAIRIE, TX. 75050	MFDR Tracking #: M4-09-B412-01
Respondent Name and Box #: ZURICH AMERICAN INS. CO. REP. BOX # 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "Timely filed within 95 days of DOS" and "No EOB / NPI #1881895852 provided in Box 33a"

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought –$349.80
3. CMS 1500s
4. EOBs
5. Medical records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "…The services were denied reimbursement because they were not timely filed, having been received by the Carrier on June 29, 2009…."

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Date(s) of Service (DOS)	CPT Code(s) and Calculation(s)	Denial Code(s)	Part V Reference	Amount Ordered
8-20-08	72052 73030-RT	29 & 200 29 & 200	1, 2, 3, & 5 1, 2, 3, & 5	$93.64 $44.12
8-22-08	99213	29 & 200	1, 2, 3, & 5	$84.72
9-12-08	99214	No EOB	1, 3, 4, & 5	$127.32
Total Due:				$349.80

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code 402.00128(b) (7) titled *General Powers and Duties of Commissioner* authorizes the Commissioner to enter appropriate orders. The Division will resolve medical fee disputes according to Rules 133.305, 133.307, 133.20(b), 133.200, 133.240 and Rule 134.203 titled Medical Fee Guideline for Professional Services effective for professional medical services provided on or after March 1, 2008.

1. These CPT Codes were denied reimbursement by the insurance carrier based upon denial reason codes "29"-the time limit for filing has expired and "200"-per 134.801, a medical bill shall not be submitted later than the 1st day of the 11th month (<08/31/05) or 95 days (>09/01/05) after DOS.

2. Rule 102.4(h), titled General Rules for Non-Commission Communication, states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

(1) the date received, if sent by fax, personal delivery or electronic transmission or,
(2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

1. Section 408.027(a) of the Labor Code states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

3. The Requestor provided written documentation to the Division supporting that the medical bill(s) were submitted timely to the carrier. Specifically, the Requestor submitted a copy of a carrier letter dated 11-18-08 which deemed these bills as incomplete and they were returned to the Requestor due to the NPI number missing in Boxes 24j and 32a. In accordance with the 'Texas clean claim guide', the NPI number requirement for Box 24j is only required if the rendering provider is a licensed health care provider eligible for an NPI and the provider is different than the provider listed in Box #33. In accordance with the 'Texas clean claim guide', the NPI number for Box 32a is considered 'optional' and is not a required/mandatory field. The NPI number of the rendering health care provider is required in Box 33a. A review of the CMS 1500 forms identify that the Requestor did originally bill with the NPI number in this field, deeming these bills as complete and were submitted timely. Payment is recommended pursuant to Rule 134.203 (b) and (c) (1).

- 72052: $52.83 divided by 38.087=1.387 x $67.51=$93.64
- 73030: $52.83 divided by 38.087=1.387 x $31.81=$44.12
- 99213: $52.83 divided by 38.087=1.387 x $61.08=$84.72
- 99214: $52.83 divided by 38.087=1.387 x $91.79=$127.32

4. Neither party submitted EOBs for this DOS. Pursuant to Rule 133.307 (c) (2) (B), the Requestor did submit convincing evidence of carrier receipt of their 'rebills' and of their 'requests for reconsideration' via a signed U.S.P.S. certified mail receipt. This DOS is eligible for reimbursement.

5. Per review of Box 32 on the CMS-1500 forms, zip code 75050 is located in Dallas County. The maximum reimbursement amount under Rule 134.203 (b) is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code 402.00128(b)(7)
Texas Labor Code 408.027(a)
Texas Labor Code Sec. §413.031 and §413.0311
28 Texas Administrative Code Sec. §102.4(h)
28 Texas Administrative Code Sec. §133.305
28 Texas Administrative Code Sec. §133.307
28 Texas Administrative Code Sec. §134.801(effective 9/1/05)
Subchapter G, Chapter 2001, Texas Government Code
28 Texas Administrative Code Sec. 134.203
28 Texas Administrative Code Sec. 133.20(b)(effective 5/2/06)
28 Texas Administrative Code Sec. 133.2
28 Texas Administrative Code Sec. 133.240

PART VII: DIVISION DECISION

The Division hereby orders the Respondent to reimburse the Requestor in accordance with Rule 134.203 plus interest for services included in the original bill(s) within 30 days of receiving this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en espanol acerca de esta correspondencia, favor de llamar a 512-804-4812.